Wasting Reset

Wasting prevention, early detection and treatment to catalyse action and accountability

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4 | Treatment scale-up

Solutions from the wasting treatment scale-up working group

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Key messages

In summary, this brief recommends:

The integration of child wasting treatment in strengthened health systems: This approach will support the earlier detection of wasting and referral for treatment for wasting, including infants who are born wasted or who become wasted in early infancy. It will ensure that the necessary workforce is in place and is well-trained, that nutrition supplies are available, and that sufficient funding is allocated to ensure there is the capacity to absorb the wasting caseload and accommodate surges in need (such as seasonally or in crises).

Optimising the efficiency of child wasting service delivery: In order to reach more children with treatment, the scale-up of quality, child wasting services needs to build on evidence-based approaches and needs to include innovations, adapt to specific contexts, and optimise service delivery at all levels. This includes supporting a continuum of care for wasted children and simplifying and contextualising treatment approaches.

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Background

Wasting is one of the most significant contributors to child mortality, with wasted children 11 times more likely to die than well-nourished children.[1] The mortality risk makes addressing wasting an essential action to enable children to survive and thrive. When prevention fails, treatment becomes vital. It is critical to intervene early in the manifestation of wasting, and to provide high-quality treatment to all malnourished children regardless of the context.

Efforts over the past decade to scale-up wasting treatment have shown mixed success, with treatment coverage remaining unacceptably low: only one in three severely wasted children receive treatment and one in five children receive treatment for combined moderate and severe wasting.[2] Treatment coverage for infants under six months is even lower.[3] As a result, there is an urgent need for increased efforts to scale-up treatment services.

The United Nations Global Action Plan on Child Wasting: Framework for Action (GAP)[5] identifies wasting treatment scale-up as one of four main pathways to reduce the global burden of wasted children.[5] This working group has identified specific game changing solutions to bring the treatment of wasting to scale, that build on the GAP Framework, the 'No Time to Waste' initiative from UNICEF,[6] the recent community-based management of acute malnutrition (CMAM) conference organised by Concern Worldwide,[7] and the WHO Road to Universal Health Coverage publication.[8]

Progress and achievements

There have been numerous achievements that have contributed to the ongoing effort to scale-up wasting treatment. These include (but are not limited to) the following:

1. **Improved coverage in treating wasting:** The CMAM model has enabled considerable improvements in the coverage of wasting treatment, with children receiving effective treatment even where health facilities are less accessible. Consequently, 5.7 million children under five years of age accessed treatment for severe wasting in 2019, compared to 1.1 million in 2009.[9] This increase was possible due to:
   a. the availability of ready-to-use therapeutic food (RUTF),

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[1] United Nations Children's Fund (UNICEF) (2021). *No Time To Waste: UNICEF's approach for the prevention, early detection, and treatment of wasting in early childhood*.

[2] World Health Organization (WHO) (2020). *Global action plan on child wasting: a framework for action to accelerate progress in preventing and managing child wasting and the achievement of the Sustainable Development Goals.* WHO, Nutrition and Food Safety.

[3] Emergency Nutrition Network (ENN). (2016) *Management of Acute Malnutrition in Infants under 6 months (MAMI) Interest Group Meeting Report.*

[4] In June 2019, the UN Secretary General commissioned UN agencies working on nutrition (the Food and Agriculture Organization (FAO), United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP) and World Health Organization (WHO)) to prepare the first-ever GAP on Child Wasting. The plan aimed to respond to the slow progress towards achieving the Sustainable Development Goal on reducing childhood wasting, and to respond to growing calls for a more coordinated and streamlined UN approach to addressing this challenge. See: About - **What is the GAP? (childwasting.org)**

[5] WHO (2020) *Global action plan*.

[6] UNICEF (2021). No Time.

[7] Concern Worldwide. (2021). *CMAM 20 years on: Going to scale in fragile contexts*. Available from: **https://www.concern.net/cmam2021**

[8] WHO (2019). *Primary Health Care on the Road to Universal Health Coverage: Monitoring Report*.

[9] No Wasted Lives. (2019). The State of Acute Malnutrition: A Platform for Communication. Available from: **https://www.nowastedlives.org/state-of-acute-malnutrition**

b. robust operational research that provided evidence regarding the safety and effectiveness of outpatient community-based treatment,
c. the use of mid-upper arm circumference (MUAC) as an independent indicator of risk for wasted children,
d. the endorsement of community-based treatment by the WHO in 2007,
e. the development of government-led and endorsed national protocols and national training curricula for the management of wasting, and continued capacity building for health workers,
f. optimisation of service delivery mechanisms to ensure that even those in poorly accessible regions are reached.

Despite the tenfold increase in treatment coverage over the last ten years, regional differences remain. There has been a considerable increase in treatment coverage, mainly in Africa, but coverage remains stubbornly low in other regions, particularly Asia, despite that continent having the greatest number of children who are wasted.[10] We know that around 70% of severely wasted children globally do not have access to the treatment they need, and that the percentage is even higher outside of humanitarian settings.[11]

2. **Efforts are being made to provide continuity of care for wasting treatment:** The number of countries that provide treatment for severe wasting within their national health systems has increased significantly, now standing at over 70 countries and covering more than 18,500 health facilities.[12] Existing and new initiatives are working towards providing a continuum of care across nutrition and health to enable greater scale-up of wasting treatment within health services, from health facilities to communities. Promising developments that are well underway include an integrated care package targeted at small and nutritionally at risk infants under six months of age and their mothers,[13] and innovations such as the modified/adapted approaches to case management.[14] There are also strides being made to provide a continuum of care across different types of malnutrition (severe and moderate wasting, stunting, micronutrient deficiencies and overweight), and across preventative and management services, which all support the vision of more integrated, multi-faceted services.

3. **Wasting management was included within the WHO Essential Nutrition Actions,[15] and Essential Nutrition Actions in Universal Health Coverage:[16]** The ongoing national and global universal health coverage approach and discussions offer an opportunity to ensure that wasting is detected earlier and is appropriately treated, that treatment and prevention are included as priority services, and that national wasting targets are set, especially for high-burden countries. Furthermore, the Tokyo Nutrition for Growth (N4G Summit) core commitments on the integration of nutrition in universal health coverage and the management of wasting in fragile and conflict-affected contexts are key to the scale-up of wasting treatment.

4. **Improved UN coordination on the prevention and treatment of child wasting:** Ongoing GAP efforts by UN agencies and other stakeholders involved in the management of wasting has resulted in a collaborative framework for collective and aligned actions on child wasting. The process has involved jointly supporting governments in the development of country-specific GAP Operational Roadmaps. This has helped clarify roles and responsibilities among UN agencies to overcome the traditionally siloed approach to wasting treatment and to improve both coordination and resource utilisation. This provides an avenue to place country priorities at the heart of global agendas on wasting management.

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[10] No Wasted Lives. (2018). *A research agenda for acute malnutrition: A statement from the Council of Research & Technical Advice on Acute Malnutrition (CORTASAM).*
[11] WHO. (2020). *Global action plan*.
[12] No Wasted Lives (2019). *The State of Acute Malnutrition;* United Nations Children's Fund (UNICEF), World Health Organization (WHO), International Bank for Reconstruction and Development/The World Bank (2021). *Levels and Trends in Child Malnutrition: Key Findings of the 2021 Edition of the Joint Child Malnutrition Estimates.*
[13] MAMI Global Network (2021). MAMI Care Pathway Package. Available from: **https://www.ennonline.net/mamicarepathway**
[14] Simplified Approaches (2021). Available from: **https://www.simplifiedapproaches.org/**
[15] WHO (2019). *Essential nutrition actions: mainstreaming nutrition through the life-course*.
[16] WHO (2019). *Nutrition in universal health coverage.*

Challenges and change needed

Despite the progress, there are still many barriers to the scale-up of wasting treatment, including inadequate financing and supply chains, poor capacity at community, sub-national and national levels to plan, equip, implement and monitor wasting treatment services, and the lack of integration of wasting in relevant systems and services. We have identified the key changes that we think are needed to overcome the barriers to wasting treatment scale-up:

1. ***Integrate child wasting treatment in strengthened health systems:*** Further integration of essential nutrition actions in routine health services can help ensure that the scale-up of wasting services is budgeted for and planned in service provision, and that more efforts are made to include wasting services at all levels and across the health system. Coordination efforts and leadership must come from both the health and nutrition sectors, with child wasting being seen as a public health intervention, with a shared responsibility between global and national health and nutrition actors. This approach will support the earlier detection of wasting and referral for treatment for wasting, including infants who are born wasted or who become wasted in early infancy. It will ensure that the necessary workforce is in place and is well-trained, that nutrition supplies are available, and that sufficient funding is allocated to ensure there is the capacity to absorb the wasting caseload and accommodate surges in need (such as seasonally or in crises). In contexts with a high burden of malnutrition, where health systems are already overburdened, under-resourced and unable to meet demand, systems strengthening and additional resourcing remains vital, while interim and alternative solutions will be needed to support and complement government services.

2. **Optimise the efficiency of child wasting service delivery**: In order to reach more children with treatment, the scale-up of quality, child wasting services needs to build on evidence-based approaches and needs to include innovations, adapt to specific contexts, and optimise service delivery at all levels:

   a) ***Support a continuum of care for wasted children:*** The current treatment model for wasting classifies children into the categories of severe or moderate wasting, and then provides these children with separate treatment services. Under this system many countries struggle with problems of high default rates (losing children as they move between programmes), low coverage (not reaching all those in need), and strain on capacities. We need to improve the continuum of care for wasted children, starting from preventative interventions related to maternal malnutrition, moving to the management of small and nutritionally at risk infants under six months, and through to the early detection, referral, and treatment of all wasted children, and we need to prevent these children from relapsing.

   b) ***Simplify and contextualise treatment approaches:*** The complexity of current treatment protocols makes it difficult for health providers to efficiently add wasting services to their workload. Improved coverage with adapted approaches to treatment offers the potential for greater coverage and public health impact than is currently being achieved. The different "simplified approaches"[17] are just one group of modifications to the standard protocols that can increase access to and uptake of interventions addressing wasting. Context-specific service delivery models are urgently needed to reach those that do not currently have access to basic health and nutrition care in both emergency and non-emergency settings, to ensure those most at risk of mortality and morbidity have timely access to treatment, and recover.

[17] Simplifiedapproaches.org includes adapted/modified approaches to wasting treatment.

Actions

How will change happen

Change needed	Specific actions required	By whom?
1 Integration of child wasting treatment in strengthened health systems	**1.1.** Scale-up the integration of wasting treatment services as part of the essential health services package and in national health plans and universal health coverage roadmaps and budgets, under the leadership of global and national health actors.	Governments, donors, UN agencies, NGOs
	1.2. Integrate nutrition assessment and action for child wasting, and small and nutritionally at risk infants under six months of age at all health and nutrition contact points in nutrition guidelines and policies.	Governments
	1.3. In fragile contexts, develop interim community-based and private sector solutions that augment (but do not solely rely on) government health structures.	Governments, NGOs, private sector, communities
	1.4. Ensure that health professionals have the essential minimum standard equipment, supplies and skillsets to effectively manage child and infant wasting.	Governments, donors, UN agencies, NGOs
	1.5. Regularly update nutrition training curricula to ensure they are in line with global recommendations for pre-service and in-service capacity building.	Governments, donors, UN agencies, academia, NGOs
	1.6. Ensure RUTF is included in essential medicines or commodities list to be routinely procured by national governments.	Governments, UN agencies
	1.7 Develop costing tools to accurately estimate wasting services costs at all levels for ministries of health and partners, and ensure integration in health budgets and plans.	Governments, academia
2 Optimisation of the efficiency of child wasting service delivery	**2.1.** Develop and/or strengthen referral pathways and shared planning between services, such as maternal nutrition, antenatal, child health and wasting treatment services.	Governments
	2.2. Develop and support the implementation of context-specific scale-up plans for modified/adapted approaches to treatment (including community health worker treatment at community level), which includes generating evidence on what works.	Governments, UN agencies, NGOs, communities
	2.3. Develop context-specific methods that can be integrated with national health information systems to more accurately estimate the annual and seasonal burden of wasting, to inform service planning.	Governments, UN agencies, academia
	2.4. Develop and implement innovative community-led service delivery models that create, support and sustain demand for wasting services by communities, including the most remote and vulnerable ones.	Governments, UN agencies, NGOs, communities
	2.5. Ensure new evidence-based cost-effective RUTF formulations are taken to market and that capacity for local production is enhanced.	Governments, private sector
	2.6. Prioritise the financial resources available for the treatment of child wasting to protect children at highest risk of death.	Governments, donors, UN agencies, NGOs
	2.7. Engage the private sector in programming and innovations and develop a public–private partnership framework and accountability to maximise potential and to safeguard against conflicts, to protect the most vulnerable.	Governments, private sector, UN agencies, NGOs, communities

Note: Finance and supply-specific actions are further developed under the financing and products working groups.

Annex 1

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The content of this brief reflects the work and views of the working group members convened under the coordination of Minh Tram Le (UNICEF) and Anne Walsh (The Power of Nutrition) and facilitated by Brenda Akwanyi, Eilise Brennan and Gwénola Desplats (ENN).

The brief draws on the professional experience of those individual members who engaged in a personal capacity in order to represent the nutrition sector as a whole, and does not reflect the position of any single institution. Where complete consensus on points was not achieved within the group, the majority view was used.

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